2012 Behavioral Health Integration Public Stakeholder Process
Draft Chronic Health Homes Workgroup Report as of August 2012

The Workgroup Process

Executive Summary

The Chronic Health Homes Workgroup (hereinafter "Workgroup") met monthly beginning in May and concluding in August 2012. The Workgroup presented a wide array of information on chronic health homes and welcomed feedback from our stakeholder community. The Workgroup focused on achieving consensus for criteria needed to establish an innovative, well-integrated model of care that will improve the delivery of timely and appropriate services to Medicaid beneficiaries with complex chronic physical, mental, and substance use health conditions. Although this report documents the process of achieving that consensus, the Workgroup has made every effort to fully incorporate all viewpoints, including dissenting opinions.

The Department would like to thank everyone who attended and/or otherwise contributed to this Workgroup's efforts.

Charge

The Health Homes Workgroup was created to make a recommendation on a new "Health Home" service under the Patient Protection and Affordable Care Act, and make a recommendation on how the new service could be developed to support any integration model. This workgroup was charged with defining: the services to be provided; eligible consumer populations; provider qualifications; and recommending a basic payment methodology structure.

The Workgroup was led by Susan Tucker, Executive Director, Office of Health Services and Melissa Schober, Medicaid Policy, Mental Hygiene Administration.

Stakeholder Engagement

As with the other workgroups, the Chronic Health Homes Workgroup did not have formal membership, but all interested stakeholders were invited to participate by attending meetings, participating in webinars, submitting written comments, providing feedback on Workgroup products

An average of 60 in-person or webinar participants attended each meeting, representing approximately over 70 government offices, health programs, and advocacy groups (see page 6 for list). In addition to feedback collected at meetings and verbal discussions with the Executive Sponsor and Staff Lead, the Workgroup received several lengthy comments from provider groups and advocacy organizations.

Overview of Meetings

- May Meeting – Presented a historical overview of Health Homes, briefly reviewed the requirements set forth in the Patient Protection and Affordable Care Act, summarized action in other states, and ended with policy considerations for the next meeting.
- June Meeting – Discussed eleven BHI criteria, then presented information on other states' Health Home financing mechanisms and began discussion of consumer eligibility and services.
- July Meeting – Featured a panel discussion with two mental health and one substance use provider who had already begun to integrate and coordinate somatic and behavioral health

care. Additionally, at providers' request, provided detail on payment mechanisms in other states, including interaction with existing services.

- August Meeting – Presented draft criteria related to initial consumer eligibility, brief service descriptions, provider qualification, and payment methodology. The presentation was followed by a robust question and answer period.

Work Products

The Workgroup prepared PowerPoint presentation for each meeting. In addition, the participants were provided with electronic copies of other Medicaid State Plan Amendments, summaries of private and state-based health homes, Section 2703 of the Patient Protection and Affordable Care Act so they could review the statutory language, summaries detailing Medicaid opportunities and challenges in developing a health home under fee-for-service and capitated delivery systems, and extensive information on rate setting mechanisms.

Important Considerations

Throughout the process, the following represent common areas of concern expressed by stakeholders:

- *Leveraging existing infrastructure. T*he importance of using existing services, provider networks, data collection mechanisms, and evaluation measures to support the new Health Home service. Stakeholders also emphasized the importance of preserving consumer and family choice in participating in a Health Home.

- *Communication*. Mental health and substance use providers repeatedly emphasized the need for crosscutting integration to fulfill the requirements of a Health Home, particularly around reducing acute care facility utilization. These providers expressed strong agreement that whatever integration model is selected, it must require all providers communicate to ensure timely and appropriate whole-person care.

- *Flexibility.* Provider groups, particularly those in rural areas of state, expressed the need for the Health Home to have staff and consumer ratios, rather than minimums. Such flexibility will allow small providers continuing serving consumers with whom they have well-established, trusting relationships.

- *Children and Adolescents.* The importance of recognizing that children and youth are not typically described as "chronic ill" and that a Health Home in a prevention-focused system will need to provide a different and unique set of services to support this population.

- *Preservation of Non-Medicaid Services.* The importance of maintaining grant-funding for services such as housing, peer and social supports, employment services and other non-Medicaid services is critically important to support recovery from mental illness, substance use disorders, and/or chronic somatic health conditions. To ensure success, a Health Home must be cognizant of these social determinants of health and must be involved the coordination of such services.

Workgroup Recommendations and Model Feedback
In line with our charge, this section contains recommendations on a new Chronic Health Home service.

Consumer Eligibility: Eligibility would be limited to individuals diagnosed with an opioid substance use disorder that is being treated with methadone or buprenorphine in an Outpatient Methadone Treatment Program who also have one other chronic health condition, such as a serious and persistent mental illness, diabetes, cardiovascular disease, overweight (BMI above 25), etc.

Individuals with serious and persistent mental illness that impairs their ability to: (1) live in his/her customary setting; (2) maintain employment or attend school without support; or, (3) manage the effects of his/her mental illness also would be eligible.

Health Home Services: The six services mandated by the Patient Protection and Affordable Care Act are:

- Comprehensive Care Management: Identification of high-risk individuals via a thorough review of clinical, therapeutic, rehabilitative, and other consumer information to determine level of participation in care management services; high quality, standardized comprehensive assessment of preliminary service needs, including screening for co-occurring mental health, substance use, and somatic needs; development of consumer-centered individualized treatment plans (ITP), including consumer goals, preferences, and optimal outcomes; development of treatment guidelines that establish clinical pathways for health teams to follow across risk levels and health conditions; monitoring of individual and population health status and service use to determine adherence to or variance from treatment guidelines; and development and dissemination of reports that indicate progress toward meeting outcomes for consumer satisfaction, health status, service delivery, and costs.

- Care Coordination and Health Promotion: Care coordination would include implementation of the consumer-centered ITP through appropriate linkages, referrals, coordination, and follow-up to needed services and supports, including long-term services and peer-based support. Health Promotion would include providing health education specific to an individual's chronic conditions, development of self-management plans with the individual such as Illness Management and Recovery; education regarding the importance of routine immunizations and screenings; assisting consumers in successfully implementing their ITP plan by placing a strong emphasis on person-centered empowerment to understand and self-manage chronic health conditions; providing support for improving social networks, and providing health promoting lifestyle interventions, including, but not limited to substance use prevention, tobacco prevention and cessation, nutritional counseling, obesity reduction and prevention, and physical activity.

- Comprehensive Transitional Care: Members of the Health Home would be required to provide services designed to streamline plans of care, reduce hospital admissions, ease the transition to long-term services and supports, and interrupt patterns of frequent hospital emergency department use. The Health Home would increase consumers' and family members' ability to manage care and live safely in the community and shift the use of reactive care and treatment to proactive health promotion and self-management.

- Individual and Family Support: Services include, but are not limited to: advocating for individuals and families; assisting with, obtaining, and adhering to medications and other prescribed treatments; identifying resources for individuals to support them in attaining their highest level of health and functioning in their families and in the community, including transportation to medically-necessary services; improving health literacy; increasing ability to self-manage care, and facilitating participation in the ongoing revision of care/treatment plan.

- Referral to Community and Social Supports: Services include, but not are limited to: providing assistance for consumers to obtain and maintain eligibility for medical assistance, disability benefits, subsidized or supported housing, personal needs, peer support, and legal services, as appropriate.

- Use of Health Information Technology: Health Homes would be required to have, or have a plan to implement, an interoperable electronic health record.

Provider Qualifications: Health Homes would be required to be licensed as a Psychiatric Rehabilitation Program (PRP) or Outpatient Methadone Treatment Program. Additionally, such providers would be required to: be an enrolled as Maryland Medicaid Provider; be accredited as a Health Home by the Commission on Accreditation of Rehabilitation Facilities (CARF) (provisional designation as a Health Home for providers who are in the process of achieving accreditation); and, within three months of service initiation, have a contract or memorandum of understanding with a community inpatient facility to formalize discharge and transitional planning.

A Health Home provider would be required to propose a Health Home delivery model that the State determines to have a reasonable likelihood of being cost effective. A prospective Health Home also must have the ability to: provide round-the-clock coverage; participate in data-driven evaluation activities; implement or have a plan to implement Health Information Technology; and maintain required staff ratios. Staffing ratios for the Health Home services only as are follows:

- Nurse Care Manager: .5 full-time equivalent (FTE) per 125 Health Home enrollees

- Health Home Director: .5 FTE per 125 Health Home enrollees. Health Homes <125 enrollees may employ 1 FTE individual to serve as both the Nurse Care Manager and Health Home Director provided that individual is licensed and legally authorized to practice as a registered nurse

- Physician or Nurse Practitioner/Advanced Practice Registered Nurse Consultant: 1 hour per Health Home enrollee per 12 month period for a physician or 2 hours per Health Home enrollee per 12 month period

- Administrative Support Staff: .25 FTE per 125 Health Home enrollees.

Payment Framework: The Workgroup envisions a three-phase system based on an actuarially sound per member, per month (PMPM) payment for the six services mandated by the Patient Protection and Affordable Care Act:

- Outreach and Engagement: A Health Home could bill a reduced PMPM when attempting to enroll new consumers. This phase would be time-limited and would require documented, progressive attempts to engage and enroll the consumer.
- Intensive Care Management: A Health Home could bill an enhanced PMPM after enrolling previously unserved consumers. This phase would be time-limited and would require provision at least two of the core services each month.
- Ongoing Care Management: A Health Home would receive a PMPM for consumers already receiving care in a Psychiatric Rehabilitation Program or Outpatient Methadone Treatment program or for consumers following the "Intensive Care Management" phase.

Participating Organizations

- Alliance Inc
- Amerigroup
- Amerihealth Mercy
- Anne Arundel Medical Center
- Arundel Lodge Inc.
- Baltimore Co. Bureau of Behavioral Health
- Baltimore Crisis Response
- Baltimore Mental Health Systems
- Baltimore Substance Abuse Systems
- Catholic Charities
- Center for Addiction Medicine
- Center for Health Care Strategies
- Children's Guild
- Children's National Medical Center
- Community Behavioral Health Association of Maryland
- Core Service Agency - Alleghany Co.
- Core Service Agency - Anne Arundel Co.
- Core Service Agency - Carroll Co.
- Core Service Agency - Cecil Co.
- Core Service Agency - Charles Co.
- Core Service Agency - Harford Co.
- Core Service Agency - Howard Co.
- Core Services Agency – MidShore Mental Health Systems
- Core Service Agency - Montgomery Co.
- Core Service Agency - Prince George's Co.
- Delmarva Foundation
- For All Seasons, Inc.
- Harris Jones Malone, LLC
- Health Care Access Maryland
- Health Facilities Association of Maryland
- Institute for Behavior Resources, Inc/REACH Health Services
- Johns Hopkins
- LifeBridge Health
- Magellan Health
- Maryland Coalition of Families for Children's Mental Health
- Maryland Department of Aging
- Maryland Department of Budget and Management
- Maryland Department of Health and Mental Hygiene - Office of Eligibility
- Maryland Department of Health and Mental Hygiene - Office of Health Services
- Maryland Department of Health and Mental Hygiene - Office of Planning
- Maryland Department of Legislative Services
- Maryland Mental Hygiene Administration
- Maryland Physicians Care
- Maryland Psychiatric Society
- Medstar Health
- Mental Health Advocate
- Mental Health Association
- Mental Health Net
- Mosaic
- Mountain Laurel Medical Center
- Mountain Manor
- National Alliance on Mental Illness in Maryland
- National Council on Alcoholism and Drug Dependence of Maryland
- Omni House, Inc.
- On Our Own of Maryland, Inc.
- Open Society Institute
- Pathways, Inc.
- People Encouraging People, Inc.
- Primary Care Coalition
- Prologue, Inc.
- Public Policy Partners
- Sante Group
- Self employed
- Sheppard Pratt
- The Children's Guild
- The Hilltop Institute
- Total Health Care, Inc.
- University of Maryland, School of Social Work, Innovations Institute
- University of Maryland - Systems Evaluation Center
- University of Maryland - Division of Child and Adolescent Psychiatry
- Upper Bay Counseling & Support Services, Inc.
- Value Options
- Volunteers of America, Cheasapeake
- Way Station, Inc.